Medicare coverage of kidney dialysis and kidney transplant services

A supplement to Your Medicare Handbook

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Medicare and treatment for permanent kidney failure

This supplement to *Your Medicare Handbook* explains the special rules for Medicare coverage and payment of kidney dialysis and transplant services.

Medicare hospital insurance and medical insurance help pay for a wide range of other health services and supplies in addition to kidney dialysis and transplant services which are needed by people with permanent kidney failure.

If you have Medicare because of permanent kidney failure, you have the same protection that all other Medicare beneficiaries have.

Your Medicare Handbook describes the other health services and supplies that are covered by Medicare and how payments are made by each part of the program. If you don't have a copy of the handbook, you can get one at any social security office.

Who is eligible for Medicare

There are three groups of people who are eligible for Medicare:

- Almost all people age 65 or over, even if they are still working
- Disabled people under age 65 who have been entitled to social security disability payments for 24 consecutive months or who meet work requirements under the railroad retirement system
- Almost all people, regardless of age, with permanent kidney failure when they need maintenance dialysis treatments or a kidney transplant

To be eligible for Medicare under the kidney disease provision of the law, you must have worked long enough in a job under the social security or railroad retirement

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system or be the wife, husband, or dependent child of a worker with enough social security or railroad retirement work credits. **Only** the family member with permanent kidney failure is eligible for Medicare. Other members of the family are not.

When Medicare protection begins

When you become entitled to Medicare because of permanent kidney failure, your Medicare protection starts on the 1st day of the 3rd month after the month your course of maintenance dialysis treatments begin. For example, if you began receiving maintenance dialysis treatments in July, your Medicare coverage would start on October 1st.

There are two ways Medicare protection can begin earlier.

- Medicare coverage can begin in the *1st month* of a course of dialysis if you participate in a self-dialysis training program in a Medicare-approved facility prior to the 3rd month after the course of dialysis begins, *and* you are expected to complete the training and self-dialyze thereafter.
- Medicare coverage can begin the month you are admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplant *if* the transplant takes place in that month or within the 2 following months. However, if the transplant is delayed more than 2 months after the initial hospitalization for preliminary procedures, Medicare coverage will begin the 2nd month prior to the month the actual transplant takes place or, if earlier, the 1st day of the 3rd month after maintenance dialysis began.

Anyone with permanent kidney failure who needs maintenance dialysis or a transplant and who is not now covered by Medicare should apply at once at any social security office.

When Medicare protection ends

The rules for whether Medicare coverage can end are different for each of the three groups of people entitled to Medicare. These rules are based on specific provisions in the Medicare law.

For people entitled to Medicare *only* because of permanent kidney failure, Medicare protection ends 12 months after the month they no longer require maintenance dialysis treatments or 36 months following the month of a kidney transplant. However, if the transplant fails during or after that 36-month period so the person again needs maintenance dialysis or another transplant, Medicare coverage will continue or be reinstated immediately without a new waiting period.

Medical insurance can stop at any time for failure to pay premiums or if you decide to cancel this part of your protection.

People entitled to Medicare because they are 65 or over or disabled should refer to pages 46 and 47 of *Your Medicare Handbook* for information about events that can end their Medicare coverage.

The two parts of Medicare

As you read about Medicare coverage of kidney dialysis and transplant services, you should be familiar with the basic differences between the two parts of Medicare—hospital insurance and medical insurance. This section briefly describes each part. For more detailed information, see *Your Medicare Handbook.*

Hospital insurance

Almost everyone who is eligible for Medicare is covered by hospital insurance without paying any monthly premiums.

Hospital insurance covers medically necessary inpatient hospital care and, under certain conditions, medically necessary post-hospital inpatient care in a skilled nursing facility and home health care. The hospital insurance part of Medicare, for example, helps pay for an inpatient stay in an approved hospital for kidney transplant surgery.

Hospital insurance has a $160 deductible during calendar year 1979. The deductible must be met each time your admission to a hospital starts a new benefit period. Medicare payments for services covered by hospital insurance are made directly to the participating hospital, skilled nursing facility, and home health agency.

Medical insurance

When you become entitled to Medicare hospital insurance because of permanent kidney failure, you are also enrolled for medical insurance. You do not have to take this part of Medicare, but most of the services and supplies needed by people with permanent kidney failure are covered *only* by medical insurance. There is a monthly premium for medical insurance protection. The current basic premium is $8.20 a month through June 30, 1979. Beginning July 1, 1979, the premium will increase to $8.70 a month.

If you became entitled to Medicare before you developed permanent kidney failure and have not signed up for medical insurance or if your medical insurance has stopped, you will have to file an application if you want this protection. The amount of your monthly premium will be the current basic rate ($8.20 through June 30, 1979). If you already have Medicare medical insurance but are paying a higher premium, the amount will be reduced to the current basic rate. You should get in touch with any social security office as soon as you know you need maintenance dialysis treatments or kidney transplant surgery.

Medical insurance covers physicians' services, outpatient hospital services, outpatient physical therapy and speech pathology services, outpatient maintenance dialysis treatments in an approved dialysis facility, durable medical equipment for use in your home such as a kidney dialysis machine and almost all items necessary for home dialysis, as well as many other health services and supplies.

There is a $60 deductible which must be met each year before payments can be made for services and supplies covered by medical insurance. The deductible can be made up of charges for any covered services and supplies. There is not a separate deductible for each covered service. After the $60 annual deductible is met, medical insurance generally pays 80 percent of the recognized charges for covered services you receive during the rest of the year.

Who can provide maintenance dialysis and transplant surgery

To receive Medicare payments, medical facilities must be specifically approved to provide maintenance dialysis or kidney transplant surgery, regardless of whether they participate in Medicare to provide other health care services covered by hospital insurance and medical insurance.

They must meet special health, safety, professional, staffing, and minimum utilization standards that are directly related to dialysis and kidney transplant services. They also must meet Federal, State, and local requirements for medical facility planning.

Your doctor or the facility can tell you whether a facility is approved by Medicare for payment of dialysis and transplant services.

Coverage of maintenance dialysis

This section explains coverage and payment for outpatient maintenance dialysis and the conditions under which inpatient dialysis is covered.

Outpatient dialysis

Medical insurance helps pay for outpatient maintenance dialysis treatments in any approved dialysis facility, including the costs of laboratory tests, equipment, supplies and other services associated with your treatment. Medical insurance payments for outpatient maintenance dialysis are always made to the facility.

Charges for maintenance dialysis will vary from one approved facility to another. The facilities' charges are based on their costs of providing dialysis treatments. The cost of treatment will depend on various factors such as costs of professional services and equipment in the area, the size of the facility, and other justifiable operating costs that can differ between one approved facility and another.

A typical charge might be $150 per treatment. In that case, if the $60 annual deductible has already been met, medical insurance would pay 80 percent of $150 (or $120). Medicare **cannot** pay the remaining 20 percent of $150 (or $30).

Occasionally, maintenance peritoneal dialysis treatments will extend overnight. These extended peritoneal treatments are covered as outpatient services by medical insurance. Consequently, any overnight stays will not reduce the number of inpatient days covered by your hospital insurance unless you require inpatient care for additional specialized services.

Many of the laboratory tests you receive are included as part of the facility's maintenance dialysis services. However, if you need additional tests,they can be covered under independent laboratory services, outpatient hospital services, or as part of your physician's services. Look under "Laboratory Tests" in the index of *Your Medicare Handbook* for page numbers explaining this coverage.

Inpatient dialysis

Generally, maintenance dialysis treatments are covered on an outpatient basis. But if you are admitted to a hospital because your medical condition requires the availability of other specialized hospital services on an inpatient basis, your maintenance dialysis treatments would be covered by hospital insurance as part of the costs of your covered inpatient hospital stay.

Please refer to pages 12 through 14 of *Your Medicare Handbook* for a detailed explanation of the coverage of inpatient hospital care.

Doctors' services and maintenance dialysis

Doctors' services are covered by Medicare medical insurance. While you are on maintenance dialysis, medical insurance can pay for your doctor's services in the following ways.

Your doctor can choose to receive a monthly payment for most of the services you will need during the month. Your doctor can use the monthly payment method whether your maintenance dialysis takes place in an outpatient dialysis facility or at home. When the monthly payment method is used, medical insurance pays 80 percent of the monthly fee minus any part of the $60 annual medical insurance deductible you have not met.

Certain additional services from your doctor which are not related to or not provided at the time of treatment of your kidney condition are not included in the monthly payment. For example, during a visit to your doctor for your kidney condition, you might receive services for bronchitis. All of the services you receive during this visit would be included in the monthly payment. But, any additional visits for follow-up care of the bronchitis would **not** be included in the monthly payment. Additional services of this kind are paid by medical insurance as explained in *Your Medicare Handbook.*

If your physician does not choose to use the monthly payment method and you are receiving dialysis treatments in an outpatient facility, your physician's services to oversee your dialysis will be included in the facility's bill for each dialysis treatment. These services include, for example, your doctor's review of your lab tests and being available to treat you, if necessary, while you are receiving dialysis treatments. When your doctor is paid in this way, any additional services—such as those needed to treat a complication that arises during dialysis—and services you need when you are not being dialyzed

would be paid by medical insurance as described in *Your Medicare Handbook.*

If you self-dialyze—either in an outpatient facility or at home—and your doctor does not choose the monthly payment method, **all** of his or her services would be paid by medical insurance as described on pages 23 and 24 of *Your Medicare Handbook.*

Self-dialysis training

Self-dialysis can be the best way for many people to continue maintenance dialysis. These people, of course, need to be taught how to self-dialyze. If they will be dialyzing at home, the persons who will help them also need instruction. Self-dialysis training is covered by Medicare medical insurance on an outpatient basis.

Coverage of self-dialysis training includes instruction of the patient and the person who will assist the patient with maintenance self-dialysis at home. Generally, Medicare **cannot** cover the cost of paid dialysis aides to assist self-dialysis patients at home, except under certain conditions described on page 14.

In addition to instruction, medical insurance coverage of dialysis training includes the maintenance dialysis treatment and laboratory tests and other supplies and services associated with the treatment.

Medicare **cannot** cover the costs of transportation to and from the outpatient dialysis center, lost wages of the patient being trained and the person assisting the patient, or cost of lodging during training.

Charges for self-dialysis training sessions may be higher than for dialysis treatments. While charges will vary from one dialysis facility to another, depending upon the type of facility and its geographic location, a typical charge might be $170 per session. If the annual deductible has already been met, medical insurance would pay 80 percent of this charge (or $136). Medicare **cannot** pay the remaining 20 percent of the charge (or $34).

For the services of the doctor who is responsible for conducting all of your self-dialysis training, the maximum total charge medical insurance will recognize is $500. If this maximum charge is made, medical insurance would pay 80 percent of $500 (or $400) if the deductible has already been met. Medicare **cannot** pay the remaining 20 percent (or $100).

Retraining for self-dialysis—for example, in the use of new equipment—is also covered by Medicare medical insurance on an outpatient basis.

Home dialysis

Many people choose self-dialysis because they want the convenience of continuing their treatments in their own homes. In order to assist such individuals to the fullest possible extent, medical insurance covers home dialysis equipment, all necessary supplies, and a wide range of home support services. The special provisions which apply to home dialysis are described below and on the following 2 pages.

Home dialysis equipment

Medicare medical insurance covers rental or purchase of kidney dialysis equipment for use in your home. Delivery and installation service charges are included as part of the charge recognized by medical insurance for home dialysis equipment.

After consulting with your doctor, you may decide either to buy or rent dialysis equipment. In either case, medical insurance makes monthly payments. If you decide to buy dialysis equipment, the monthly payment includes any reasonable interest or carrying charges that may be part of an installment purchase agreement with the supplier of the equipment.

After the $60 annual deductible, medical insurance pays 80 percent of the recognized monthly rental charge

or the recognized monthly installment purchase price for your home dialysis equipment.

Medical insurance payments for your home dialysis equipment can continue as long as you need to be dialyzed at home. If your need for home dialysis stops, these medical insurance payments also stop. For example, if you no longer need to be dialyzed because you have successful kidney transplant surgery, then medical insurance payments for your home dialysis equipment would usually stop.

If, however, you stop using your home dialysis equipment temporarily—for example, because you are traveling or are hospitalized—medical insurance will continue its payments for the equipment for up to 3 months after the month in which you last used the equipment. If at a later date you use the equipment again, medical insurance payments would also start again.

Of course, if you purchase your dialysis equipment, medical insurance payments always stop when the purchase price recognized as a basis for payments is reached.

A special rule applies if you obtain your home dialysis equipment from an approved hospital or facility which reserves the equipment for the exclusive use of Medicare patients on home dialysis. If you secure your equipment under this arrangement, Medicare will pay the hospital or facility for the full reasonable cost of the equipment, including installation and maintenance for as long as you need it. You do not pay any deductible or co-insurance.

Home dialysis supplies

Medical insurance covers all supplies necessary to perform home dialysis, including disposable items such as alcohol wipes, sterile drapes and rubber gloves, and forceps, scissors and topical anesthetics. After the $60 annual deductible, medical insurance pays 80 percent of the recognized charges for all covered services. Whenever

possible, you should accumulate bills until they reach $10 or more before sending in your claim for payment.

Drugs **cannot** be covered except for heparin (and, when medically indicated, the antidote for heparin) and topical anesthetics. Also, blood (or packed red blood cells) **cannot** be covered for home dialysis unless your physician administers it or personally directs its administration, or the blood is needed to prime your dialysis equipment. (See "How Medicare pays for blood" on page 17.)

Home dialysis support services

Medical insurance covers periodic support services, furnished by an approved hospital or facility, which may be necessary to assist you to remain on home dialysis. After your doctor approves the plan of treatment, such support services may include visits by trained hospital or facility personnel to periodically monitor your home dialysis, to assist in emergencies when necessary, and to *occasionally* serve as a dialysis aide (for example, when your regular partner is temporarily not available because of illness). In addition, medical insurance covers the services of qualified facility or hospital personnel to help with the installation and maintenance of your dialysis equipment and to test and appropriately treat your water supply system.

Beginning April 1, 1979, medical insurance can cover the services of a trained dialysis aide to assist with self-dialysis at home if **all** three of the following conditions are met: 1) an approved hospital or facility which is supervising your treatments provides **all** of your home dialysis equipment and supplies and support services; 2) the services of a trained aide are necessary to enable you to be on self-dialysis at home; 3) the hospital or facility has in effect a special payment agreement with Medicare.

Under these conditions, after the $60 deductible, medical insurance pays the hospital or facility 80 percent of the recognized cost of providing all covered services.

Kidney transplant surgery

Both parts of Medicare help pay for kidney transplant surgery.

What hospital insurance pays for

Medicare hospital insurance covers your inpatient hospital services in an approved hospital when you are admitted for kidney transplant surgery. Hospital insurance also covers hospital services in preparation for your kidney transplant. This includes the Kidney Registry fee and services such as laboratory and other tests that are required to evaluate your medical condition and the medical conditions of potential kidney donors. These preparatory services are covered whether they are done by the approved hospital where your transplant surgery will take place or by another hospital that participates in Medicare. If there is no kidney donor, the costs of obtaining a suitable kidney for your transplant surgery are also covered.

When your admission to an approved hospital for transplant surgery starts a benefit period, hospital insurance pays for all covered inpatient hospital services for as many as 60 days after the $160 hospital insurance deductible. If you continue to need inpatient hospital care or need to be hospitalized again during the same benefit period, hospital insurance pays for all covered services for the 61st through 90th day, *except for $40 a day.*

In addition to 90 inpatient hospital days in one benefit period, you have a lifetime total of 60 inpatient hospital reserve days. Reserve days, however, are **not** renewable. Hospital insurance pays for all covered services *except for $80 a day* for each reserve day you use. (For more information about inpatient hospital care, see "When you are a hospital inpatient" beginning on page 12 in *Your Medicare Handbook.)*

Hospital insurance pays the full cost of care for a person who donates a kidney for your transplant surgery, including all reasonable preparatory, operation, and post-operative recovery expenses in connection with the donation. There is no deductible or daily amount for your donor's hospital stay, and the number of days your donor uses does not reduce the number of inpatient days that you may use in a benefit period. Your donor's inpatient hospital stay does not qualify him or her for any Medicare benefits not associated with the kidney donation. But, your hospital insurance will pay for any additional inpatient hospital care your donor might need if there are complications that are a direct result of the kidney donation.

Medicare hospital insurance payments are made directly to the hospital.

What medical insurance pays for

Medicare medical insurance covers your surgeon's services for performing the kidney transplant operation. This includes pre-operative care, the surgical procedure, and follow-up care. Medical insurance also covers physicians' services provided to your kidney donor during his or her inpatient hospital stay while you are receiving a kidney transplant.

After the $60 annual medical insurance deductible is met, Medicare medical insurance pays 80 percent of the recognized charge for your surgeon's services and the physicians' services provided to your kidney donor.

Some approved hospitals will include your surgeon's fee in their costs for your transplant surgery. In this case, if the $60 annual deductible has already been met, Medicare pays the hospital for your surgeon's services except for 20 percent of the surgeon's fee. Otherwise, medical insurance payments for your surgeon's services are paid as explained in *Your Medicare Handbook* (see "How medical insurance payments are made" beginning on page 23 of the handbook).

How Medicare pays for blood

Both parts of Medicare can help pay for blood (or equivalent units of packed red blood cells).

Hospital insurance covers the costs of any blood you may need during a covered inpatient hospital or skilled nursing facility stay, except for the first 3 pints of blood in each benefit period.

If you receive blood in connection with services covered by medical insurance, medical insurance pays for the blood, except for the first 3 pints in each calendar year. After the first 3 pints, medical insurance pays 80 percent of the recognized charges less any part of the $60 annual deductible that is not met. If you are receiving maintenance dialysis as an outpatient of an approved hospital dialysis center, any blood you need will usually be covered by medical insurance as part of the costs of your dialysis treatment. Blood you need can also be covered by medical insurance when it is provided as a part of a physician's service and included by the physician in the charge for the service.

Medicare does not cover blood in connection with self-dialysis at home unless it is provided as part of a doctor's service or is needed solely for the purpose of priming the dialysis equipment.

If you are covered by a blood assurance program, it can usually replace the blood that is not covered by Medicare. Or, you can often arrange to have someone donate blood for you.

What Medicare does not cover

The following list shows some of the services and supplies that Medicare does **not** cover in connection with dialysis and transplant services. Pages 42 and 43 in *Your Medicare Handbook* list other services and supplies which are not covered by Medicare.

Ambulance or other transportation costs to a facility for routine outpatient maintenance dialysis

Dialysis aides' services to assist in home dialysis, except under certain conditions (See page 14)

Drugs and medicines you buy yourself with or without a prescription except heparin, the antidote for heparin, and topical anesthetics

Inpatient hospital and skilled nursing facility costs when the stay is solely for maintenance dialysis

Lodging costs when an outpatient dialysis facility is not near your home

Wage losses to you and your dialysis partner during self-dialysis training

Other payment sources

If you have health care protection from another source—for example, from private health insurance, from the Veterans Administration, the Indian Health Service, or a Federal employee's health plan—we suggest you get further information concerning its payment for services needed for the treatment of permanent kidney failure.

There are also agencies in most States that, under certain conditions, help with some of the medical expenses that Medicare does not cover. Some States have Kidney Commissions which are agencies that help people who need assistance in meeting expenses of kidney dialysis and transplant services that Medicare cannot pay.

Most States have a Medicaid program that helps pay medical expenses in cases of serious financial need.

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